MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 28, 2004
9:32 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Mandated report on eliminating physician referrals to physical therapy
-- Carol Carter

MS. CARTER: That's right. I want to first acknowledge two analysts who help me with this report, Margo Harrison and Sarah Kwon. Their work was invaluable to me.

This report mandate was included in Section 647 of the MMA. It requires us to study the feasibility and advisability of allowing Medicare fee-for-service beneficiaries to have direct access to outpatient physical therapy services.

Under current Medicare coverage rules, a beneficiary must be referred by and under the care of a physician for outpatient therapy services to be covered. Medicare does not require physical therapist to be supervised by a physician and physical therapists can directly bill for their services.

What's at issue here is the physical therapists would like to have the physician referral and review requirements eliminated. So when the term direct access is used, that's what it's referring to is the elimination of the referral and review requirements. Let's quickly review what those are.

The physical therapy services must be referred by a physician. The physician must review the plan of care every 30 days and must reevaluate the patient after 60 days for longer-term care.

Let's quickly review the Medicare coverage for outpatient therapy services. Outpatient physical therapy services are covered as long as they are furnished by a skilled professional, are appropriate and effective for a patient's condition, and are reasonable in terms of service frequency and duration. There are no time limit or visit restrictions on coverage. Coverage is limited to restorative services. Medicare does not cover physical therapy when the services maintain a level of functioning, when the therapy is considered a general exercise program or a patient no longer can benefit from therapy.

Just a couple of background points, about 9 percent of beneficiaries use outpatient physical therapy. The services are provided in a variety of settings. You can see them in the overhead. But regardless of where the services are furnished, payments are established in the physician fee schedule under Part B. And like all Part B services, the beneficiary is responsible for a 20 percent copay.

One key reason to require physician referral is to help ensure medically appropriate care. Only physicians can order and evaluate the results of lab tests and radiological exams used to assess if physical services will benefit a patient and to modulate a plan of care. Once therapy begins, physicians ensure that the plan of care continues to match patient's care needs. In short, the requirements help screen out unnecessary care and ensure proper medical attention.

If referrals were no longer required, some beneficiaries could receive unnecessary care and delays in getting more appropriate medical attention. The delays could result in worse patient outcomes.

Physical therapists counter that their training and practice ensure that patients are adequately screened for medical referrals. They note that physician referrals do not always provide much clinical guidance regarding the services to be furnished. For example, general instructions such as evaluate and treat require the same assessment skills and responsibilities that they would assume if the referral requirement was eliminated.

Medicare has similar physician requirements for other services such as home health care, skilled nursing facility stays and occupational therapy. The requirement is also similar to those in place for other practitioners such as physician assistants and nurse practitioners.

We looked a little bit at what private payors do for physical therapy services. What we found is that private payers often use a combination of strategies to control service use. Many plans, managed-care companies and self-insured plans require physician referrals. Blue Cross and Blue Shield plans vary in their requirements for physician referrals, depending on the plan and the employer. Representatives from the Blue Cross Blue Shield Association told us that even when a referral is not required, many physical therapists prefer to have one before they begin treating patients.

Most private payors restrict service use by limiting the days or visits allowed. Some private payers also use practice guidelines to recommend a course of treatment and to indicate an average number of visits for a specific medical condition.

There's considerable variation in state laws whether they explicitly allow the provision of physical therapy services without a physician referral. Most often, state laws limit in some way the services a physical therapist can provide. The most common restriction is that physical therapists can evaluate but not treat patients. Several states are silent on the issue. And in these states coverage policies of the insurers may still require physical therapy referrals. Only two states explicitly allow physical therapists to treat patients without any other restrictions.

Another concern with eliminating the referral and oversight requirements is that unnecessary care might increase. Long-standing concern about the appropriate use of outpatient therapy services has prompted the examination of the services furnished to Medicare beneficiaries. These studies, done by the Office of the Inspector General and GAO, have consistently found that medically unnecessary therapy services were frequently furnished to beneficiaries. Most often, the services were medically unnecessary because the services were not skilled, the patient did not require a skilled level of care, the treatment goals were too ambitious for the patient's condition, the frequency of the

service provision was excessive, given the patient's condition or a service was continued to be provided even though the patients had already met their goals. These studies indicate that even with physician referral and review requirements, unnecessary therapy is often provided.

Outpatient physical therapy service provision is already highly variable, suggesting that some of the services are unneeded. For example, service provision appears to increase as Medicare payment policies become less restrictive. After the implementation of the outpatient therapy caps in 1999, Medicare spending decreased 34 percent. And then, when the therapy caps were lifted in 2000, spending increased 36 percent. Spending also varies considerably, ranging from three to fivefold across states and different providers. A better understanding of the reasons for this variation, coupled with efforts to reduce it such as practice guidelines or provider profiling, would result in more appropriate service use.

Stepped up medical review of physical therapy services could help deter and reduce medically unnecessary services, but currently less than 2 percent of all outpatient therapy claims are reviewed. This scale of activity is unlikely to ensure that services provided meet coverage rules. The lack of aggressive oversight is another factor to consider in relaxing the referral and review requirements.

Proponents claim that lifting the physician referral requirement would save the program and beneficiaries money. But for some patients, the physician evaluations result in treatment other than physical therapy. For these patients, the physician referrals would result in more appropriate medical care and by eliminating unnecessary physical therapy services the current requirements may result in net savings to the program.

Supporters point to one study that compared the cost of care for patients with and without a physician referral in Maryland Blue Cross Blue Shield enrollees. This study, which was funded by the American Physical Therapy Association, found that the care provided to patients without a physician referral was shorter in duration and about half the cost of care that began with a physician referral. However, the authors acknowledge that differences in severity between the patients seen by physical therapists with and without a physician referral could explain the differences in the cost of care. We also do not know if similar cost differences would be observed in an older population.

Proponents of removing the physician referral requirement also assert that delays in care would be reduced and promote quicker recoveries. Yet most beneficiaries report that they do not encounter problems in getting special therapy services. In 2003, we found that 85 percent of beneficiaries reported having no problems, an increase from 2000. 6 percent of beneficiaries reported big problems in getting special therapy services and 8 percent reported having little problems. All but one subgroup of beneficiaries reported fewer problems in 2003 compared with 2000.

Another measure of access is the number of beneficiaries receiving outpatient therapy services. Between 1998 and 2000 the number of beneficiaries receiving outpatient therapy services grew at the same rate as the growth in the number of beneficiaries. Although this measure does not consider if the services were appropriate, the number of beneficiaries receiving services is stable.

In conclusion, there are several compelling reasons to retain Medicare's current requirements. They help ensure physical therapy services are medically appropriate and necessary. To the extent that requirements reduce the amount of unnecessary services, they result in net savings. Access to physical therapy services for most beneficiaries does not appear to be impaired. The current requirements are consistent with Medicare coverage rules for other services. Changing the requirement for physician referrals would have clear repercussions for other services. And last, the requirements are consistent with private payer strategies. All payers have some kind of restrictions in place to try to limit the amount of unnecessary service use.

I'd be glad to answer any of your questions or gather comments from you on the draft.

MR. DURENBERGER: What is it about the physician reimbursement system under Medicare that assures us that physicians only recommend medically appropriate physical therapy services?

MS. CARTER: There is nothing specific that would ensure that the services were appropriate, but I think you could assume that physicians wouldn't refer patients on for services that they didn't need.

MR. DURENBERGER: Why can you assume that anymore than you would make the assumption that physical therapists will not provide services that are medically inappropriate?

MS. CARTER: The referral requirement is the same as for many other services. I think Medicare has traditionally used physicians in the role of reasonable and necessary and that's been sort of the standard that's been used in the program really across the board for all services.

MR. DURENBERGER: I know that's the 1965 definition of Medicare and I don't think there was such a thing as a physical therapist in 1965. So I'm asking you a question which simply says where is the assurance to the system of reimbursing physicians that would give us the assurance that only appropriate referrals are made? Is there anything in the nature of the payment system today that gives the physician an incentive not to refer inappropriately?

MS. CARTER: I don't think there's an incentive either way.

DR. WAKEFIELD: A couple of comments. The takeaway for me on this, from my perspective I don't see, from this report, any compelling reason for Medicare to change from what it's currently doing in terms of expecting referrals or requiring physician

referrals. But I can tell you the tone of this report doesn't provide me with a slam dunk that there's no compelling reason not to change either. Let me just make a couple of comments about it.

First, I'm talking about some of the text specifically. There's a lot of reference to -- and this might be a little bit, I'm not sure, of what Dave was getting at. There's a little bit of text that talks about the IG studies that are cited on page seven and it indicates that there are clearly problems with the current system writ large in terms of policing the provision of unnecessary services, trying to tamp that down. You cite that series of studies. That seems to indicate to me that physician referrals don't necessarily ensure that medical necessity or appropriate utilization occurs across the board.

So in other words, just because we've got that expectation in place. those IG studies say there are flaws in that process. People are getting unnecessary care. The system is paying for it.

But on the back end, it is a major reason why we are arriving at the conclusion that we arrive at at the end. That is in your last slide, that if you keep that oversight it helps ensure PT services are medically appropriate and necessary. And yet, there is that series of studies that suggest there are big problems with it, at least in some sectors and so on. So I had a little bit of a disconnect between those two points.

I think then we're talking about keeping a key solution in place that has serious flaws. As I said, I don't think that that necessary carries over to the concluding part of the report.

The other point on that is that we indicate the findings of those IG studies but I think it also might be worth it to take a look at what was recommended to address those problems and I don't see that here.

I think, and I could be corrected on this, but I think that what you might find in terms of recommendations are things like exactly what we raise elsewhere, that is more FI oversight. That the system really ought to have more FI oversight. That was one of their solutions. And another solution, I think, was that you ought to have more provider education brought into the mix.

And I don't know that they recommended, for example -- well, I think those are sort of two of the key solutions and I think that might merit mention in this report. Because again, I see such a disconnect between our recommending a solution that clearly has problems on the front end.

And also on that very point, I'd say you talk about in the report the variation between orthopedic surgeons and primary care providers and their utilization of physical therapy services varying. And yet we're kind of coming back at the end of the report to saying this is about a problem with the potential for PTs, removed the referral requirement to overutilize.

So there's a balance in the tone of that report that bothers me a little bit. I think if we could thread those points through a little bit more to the end, that would make me feel a little

bit more comfortable.

The last point I'll make is we raise a couple of other issues, one suggesting that underlying medical conditions might be missed. Maybe. We said a lot of maybes throughout this report. That might be true.

We also know that there is -- it sounds like it's terribly small, I don't have the exact numbers from your report, but it sounds like there is a pretty small but real set of physical therapists who are exercising their own direct access and they're not seeing patients through referrals.

So I guess what I'd say is if we're going to raise some of those kind of questions, like gee there might be real problems with treatment not appropriate to the health care problem, if there is a small subset of patients that could be looked at to try and better understand what's going on there, maybe that's also worth throwing in and commenting on that, too.

That is, there is direct access. It is being operationalized. Perhaps we ought to see if, in fact, there is an increase in medically inappropriate services and/or an increase in compromises in quality of health care that are being rendered to the patient.

The last point, on the very last paragraph of this report, where you say Medicare may want to consider expanding its controls, particularly ones that are tailored to specific medical conditions. For me that question prompted an okay, on whom are those controls going to be expanded? For what? Under what circumstances? What medical conditions are we talking about? We haven't talked about, to my knowledge, any specifically to that point. So it's a lot the tone here that I'm reacting to, I guess, and just to give you a few of examples of that.

MR. HACKBARTH: Mary, are you saying that you disagree with the conclusion that we ought not -- are you saying we ought not have a physician referral requirement? Or are you saying well, even if we keep it there is abundant evidence of problems and we need to recommend some additional things as well?

DR. WAKEFIELD: That's why I started with where I end up in my comments. That is, I'm not suggesting that there is a compelling reason to lift the current requirement based on the data. I also don't think it's the slam dunk that --

MR. HACKBARTH: That the current system isn't great.

DR. WAKEFIELD: And even the text of this report would lead me to.

DR. STOWERS: Carol, I think it's a good chapter and I agree with your conclusion in the end. I wanted to clean it up a little bit.

When you say there's 6 percent that have a problem with access, I don't think there we want to be inferring that that's necessarily there because of the physician requirement that's involved there, because there's a considerable shortness of physical therapists in rural areas, and that sort of thing. That's where we tend to run into the lack of access that may be coming in that survey, rather than necessarily because of the

physician referral part.

Another thing is, just in practice from day to day, it's very rare that we do this evaluation for physical therapy in some kind of an independent state. Because you usually have a patient that's had a cardiovascular incident, or they're a diabetic with foot surgery, or something like that.

So when we get to looking at offsetting the physician's visit against the cost of savings for the physical therapy, it's very rare that there's a separate E&M there for the purpose of evaluating this physical therapy. I can't even remember the last time I had a visit that was just for that, that it wasn't part of the continuous care of the patient. Because most of these have multiple diagnoses and chronic care problems and they're being seen anyway.

And another thing, if we're going to make that comparison against those costs, I think it might help in the chapter to have what the average cost of a therapy session is versus this care that's being picked up probably as part of their routine E&M services anyway without a separate visit. So I think I'd look at that.

And then I think we have to be a little bit careful when we criticize the order by the physician for just evaluate and treat because if there's a good relationship between the physical therapist and the physician, and they're used to working together on these patients, it's sometimes a show of respect not to get in and try and micromanage the physical therapy treatment. Because I agreed with what you said a while ago, that really the physician is there to evaluate for appropriateness of the therapy, not to get in and micromanage the therapy treatments.

I just wanted to make those three points that I think would make the chapter a little clearer.

MR. SMITH: Very briefly, because Mary made the point I wanted to. The chapter does read that it would be a good idea to keep the physician and the gatekeeper role here, as we do for other services. But it doesn't work very well but let's keep it anyway.

I do think we've got to figure out some way to address the it doesn't work very well, either with more financial intermediary oversight or with some notion that we're not suggesting that we ought to do this because we ought to do it. There is a reason that we have physicians in this gatekeeper role and we ought to address the part of it that's not working. I think the report needs to reflect that tone, rather than we see no reason to change.

DR. MILSTEIN: I'd like to say even from my perspective, I think the report does a very nice job of answering the question that was asked. And I think, in the course of answering it, uncovered the fact that what we proposed to fall back on, which is physician referral doesn't work too well. But I think the report does a very nice job of answering the question that was asked.

Do we want to expand the scope of our answer to address

issues that we're not being asked to answer? If so, I have an opinion, but I'd defer to you, Glenn.

MR. HACKBARTH: It depends on how far afield you want to go. If you want to talk about bundling of surgeons in the hospital, the answer is no.

DR. MILSTEIN: I think one of the challenges here and one of the things that I think the research on appropriateness won't tell you, is that it isn't like we have any kind of a decent evidence base for knowing when a physical therapy service in a given situation is going to improve patient outcome.

If you've ever done a utilization review of physical therapy -- and I did some early in my career -- it's a very subjective game. If you really wanted to answer the question we weren't asked, which is how would you go about assuring more appropriate, a higher degree of "appropriateness" of physical therapy services, step one would be to make an investment in some outcomes research so that was an evidence base on which either physicians or the fiscal intermediary or any other third-party could attempt to impose a greater discipline between when the services were ordered and when there was some reasonable probability of the patient experiencing a health gain.

MR. DURENBERGER: That's where I was going.

MR. HACKBARTH: That's definitely not too far afield.

DR. REISCHAUER: I agree with most of the statements that have been said.

It strikes me that relative to the problems faced by private plans, by and large, Medicare doesn't have as great a degree of problem. And maybe John, would disagree with me on this, but I see it as an area every day in anecdotal evidence that I see abuse in. And 40 percent might look good.

What I was wondering is, looking at the distribution of Medicare payments and Medicare patients in the back chart, if we knew what the situation looked like for the non-Medicare population, because it strikes me that physical therapy is being provided in a very different mix than it would be for an under-65 population and a mix of institutions that, in many ways, might have, first of all, individuals with much more need, proven need, and much more supervision of what's going on.

And that if I looked at the private under-65 population, the private physical therapist would be providing a big, big, big chunk of what was going on. And while many of those services are fine, but that is the area I think that you worry about the most.

MS. RAPHAEL: I just wanted to briefly reinforce what Arnie said because in my experience it's very hard to predict who's going to be successful with physical therapy and the word appropriateness, I think, is subject to many interpretations. Because a lot of times you want to try to do restorative physical therapy but you really can't restore function and you end up just getting into maintenance. A lot of it has to do with motivation and other kind of accompanying conditions.

I would be very reluctant to look to the FIs as really the way to deal with this because I just don't think we have enough

of a clinical base here to really make those decisions. And I don't think the FI, by looking at a piece of paper, is really going to be able to make good judgments in this area right now.

I guess I also question where we want to go with this, recognizing that what other people have said, we're recommending the physician stay as sort of a control point but we also feel it's an inadequate control. But I just don't know whether or not we have enough information to make recommendations to remedy the situation.

MR. HACKBARTH: Sometimes that's reality, is that you don't have perfect options. You don't even have all the information that you would want to have. In those cases, sometimes it's better not to make any change, try to develop a better information base to guide future decision making. And I think that's where we may be in this particular case.

Any other comments on this issue?

DR. WAKEFIELD: Only if I can come behind the recommendation for more information, to say that's a little bit of part of what I was talking about when I said we might assert that there's a potential problem with quality of care. We might assert that diagnoses, for example, will get missed. But unless we take a look at good data, where we get that data from, we're not going to know the answer to that. And so we sort of put these hobgoblins up there but not the solution to try and address them.

I agree with you, Arnie, about the need for data.

MR. HACKBARTH: I may just pick up specifically on Carol's point about urging increased FI activity. One of the concerns that I personally had and the Commission itself has expressed concern about variability in FI decisions, particularly in the absence of definitive evidence about what works and what does not. So just saying well, we don't know what to do but you go in there and police it is not a recommendation that I personally feel all that comfortable with.

DR. MILSTEIN: Again, I don't know whether you want to expand the evidence we look at in coming up with recommendations. But if we do and we have the resources, one area of American health care activity where this is a front and center issue in terms of volume and appropriateness is worker's comp care. And if you begin to look at, as states have struggled in worker's comp laws, to figure out how you get the right amount of physical therapy to a population but not, in the course in doing so, risk a lot of extra services, I think there is some useful lessons that may be applicable in terms of what control mechanisms work.

In many states, for example, looking to some external presumed neutral source of authority in the absence of an evidence-base and coming up with treatment guidelines that diagnosis specific is where they've gone. The American College of Occupational Medicine has come up with guidelines for physical therapy and similar services. A number of state worker's comp systems have begun to say we're going to presume that that is the right amount of volume of services that somebody needs given a

condition.

As you listen to it on the face of it, you can see what might be imperfect about that one-size-fits-all solution. But nonetheless, I think there is some useful information as to how to better control these services that can be culled out of 50 different states struggling with the question of physical therapy appropriateness in worker's compensation care.

MR. HACKBARTH: Okay. Thank you, Carol

Before we do the public comment period, we need to return to the issue of the mandated report on benefits design and cost-sharing in Medicare advantage plans. We were there eight hours ago or thereabouts, as you will recall. And based on the discussion this morning, Rachel and Jill have put together some draft recommendations that we think reflect the input that they got this morning. So we're going to review those.

I don't think we need to go into details about the wording and format. Think of these more in terms of the basic substance. I think the process, and correct me if I'm wrong Mark, is that we want to hear your reaction to them, hear if they basically capture the substance of what you want. And then we will refine them and bring them back to the next meeting for the final vote. Or even tomorrow. That would be even better. We can do that tomorrow.

DR. MILLER: Think through them, we tinker with things, and then everybody's in place, we can knock this out in 10 or 15 minutes tomorrow.

DR. SCHMIDT: Here is how we have crafted recommendation number one. To provide critically important about the implications of coverage and benefit options, CMS should use an array of approaches for beneficiaries and those who help them. In the short-term, CMS should continue to provide estimates of out-of-pocket costs for 2006 on the Medicare Personal Plan Finder; begin to make available more advanced consumer decision tools that reflect out-of-pocket costs under various scenarios for use of services and their likelihood. Over the longer-term, CMS should develop tools that use individuals actual experience to project future out-of-pocket spending.

Here's recommendation number two. CMS should interpret its authority granted in the MMA to negotiate with MA plans broadly. Specifically, MedPAC believes the Agency has authority to set minimum standards for benefits and should use this authority to ensure that plans do not discriminate on the basis of health status. The Congress may need to provide CMS with additional staff resources and administrative flexibility to carry out this function effectively.

And the final one, to prevent discriminatory benefit designs, CMS should develop guidelines for plans on benefit design and cost-sharing that, if adopted, would provide safe harbor from extensive negotiations with the Agency. Plans could choose between an out-of-pocket cap on cost-sharing for Medicare-covered services provided within the plan's network or limitations on cost-sharing to prevent disproportionately high

cost-sharing on services that are less discretionary in nature such as chemotherapy.

MR. HACKBARTH: Okay. Why don't we go back to the first one and ask for comments one by one.

Any comments on number one?

DR. MILSTEIN: For reasons I think I previously explained, I would certainly like to see the over the longer-term language replaced with as soon as feasible or something like that. The other industries figure this out.

MR. HACKBARTH: Okay.

DR. SCANLON: I think that in your presentation this morning, you talked about the the fact that distributional information would be useful to beneficiaries. And that actually that's part of that first sub-bullet under number two, which is it's a lot less than an advanced consumer decision tool. It's really some pretty basic statistics that you could get out of the same data that you're using now to give them averages.

MR. HACKBARTH: So you're saying we make it sound more difficult than it is.

DR. SCANLON: That first bullet is too modest, continue to provide estimates of out-of-pocket costs. I would say to continue what the currently provide and expand information on out-of-pocket costs. It's short of this more advanced consumer decision tools which, I think, are future steps.

DR. MILLER: That's what the second dash is supposed to speak to, continue doing what you're doing and expand.

MS. RAPHAEL: I feel like Bill was saying, continue doing what you're doing, they can do more. The average is what they're presenting now.

DR. SCANLON: I think if we talk about in the body the advanced consumer decision tools, we're talking about things like we had this morning, the issue of being able to bring in your own experience or being able to develop a scenario based on other information.

There's a lot of things that are a whole lot more basic and I think that they're in the spirit of the first one, which is CMS is already calculating average out-of-pocket costs. But they're not telling you what the 98th percentile is going to be.

MR. HACKBARTH: Let me just see if I've got this right. The first bullet, continue to provide estimates, is there because it's our understanding that they plan to stop doing even that; right? Or are considering not doing that. And so we're just trying to be explicit in saying we want them to keep what they're doing.

The second dash, begin to make available more advanced tools, to me sounds like it may be a little bit too grandiose. What we're talking about is stuff like Walt Francis did for years and I think is still done in the Consumer Checkbook for Federal Employees. Just saying under different basic scenarios about your health care costs, this is what you would incur under different plan options. It's really not high-tech. It's pretty basic. Is that what you're referring to?

DR. SCANLON: Yes. Maybe it's the language advanced.

DR. REISCHAUER: Advanced consumer tools I thought were in Arnie's.

MR. HACKBARTH: Then the last bullet over the longer-term, or modified as Arnie requested, is where we start to individualize it based on actual historical evidence about that particular patient's experience.

DR. MILLER: So we'll swap the language around. In the dash, we'll refer to it as tools. And then in the final bullet, we'll refer to it as more advanced consumer --

MR. HACKBARTH: I think that would do it.

DR. BERTKO: Not to completely disagree with Arnie, but I think CMS has got a lot to do here. I had some input on the Plan Finder a couple of years ago. I think the job they have to insert Part D is so important into the short-term bullets that I personally like the last bullet's wording, over the longer-term, as opposed to as soon as possible.

Also, with our plan who does do this, it took several years to get all of our systems, and we're a little bit more than a single platform. But it's fairly complex.

MR. HACKBARTH: Other comments on number one?

MR. SMITH: Very quickly, I thought we had had earlier a third short-term bullet, which was to ensure that 1-800-Medicare and the SHIP programs had adequate resources. It seems to me we ought to add that back in. DR. SCHMIDT: We weren't clear whether you wanted that as a recommendation or in the text.

MR. SMITH: I'd be happy with it in the text, just clearly there.

MR. HACKBARTH: On this issue of as soon as possible or over the longer-term, ultimately under as soon as possible, CMS is the arbiter of how soon that is. I think we could address that again in the text by just saying we recognize the Agency has got a lot going on and as soon as possible we'd like to see this happen.

So I think were in agreement on number one. Okay, let's go to number two. Any comments on number two?

DR. SCANLON: Unfortunately, let me make a legal comment, as a nonlawyer. That is the issue that already in the statute is a requirement that MA plans provide Medicare Part A and Part B benefits. So given that there's that kind of language, what does it mean to say that CMS has the authority to set minimum standards for benefits?

I was mentioning to Rachel and Jill earlier at the lunch break that when they said that CMS had interpreted their negotiating authority narrowly, or more narrowly than OPM maybe has, I was wondering if it was, in some respects, the various things are in the law about what MA plans are supposed to do that OPM doesn't have similar kinds of prescriptions in the law.

DR. MILLER: What about this? What about we cut out the reference to the authority for minimum standards and just say MedPAC believes the agency has the authority to ensure -- and pick up the last clause of it -- to ensure that the plans do not discriminate on the basis of health status, as contemplated by

the -- I wouldn't put those words in. Just cut it down to that last phrase and I'm saying that because they have the wide authority granted to them in the MMA.

DR. REISCHAUER: The chapter that we're talking about here, or the report, deals with benefit design. They can discriminate -- there are lots of tools for discrimination. And I think we want to focus on the fact that this uses authority to ensure that plans do not use benefit design to --

MR. SMITH: It's really not even benefit design. It's a broader question of design, in our case, focusing on copays. It has nothing to do with whether or not the benefit is there. The benefit has to be there, which is Bill's point. It should be plan design, or some broader phrase.

MR. HACKBARTH: I like Mark's proposed shortcut. Do people understand what he said and agree with that?

DR. BERTKO: My only insertion, and it's probably not needed, would be a for example before the word plans could choose between.

MR. HACKBARTH: I'm sorry, I didn't follow that, John.

DR. BERTKO: I don't want the two bullets there to necessarily be prescriptive. And instead it would be for example -- on the sixth line. For example, plans could choose between...

MR. HACKBARTH: You want to add for example, that's the change?

DR. BERTKO: I mean that not as an editor today here, but just to say that these two don't necessarily have to be the ultimate decision by CMS. But there are two examples of safe harbors that would be useful.

MR. HACKBARTH: I agree with that.

DR. SCANLON: I've forgotten what we exactly say in the conclusion, by I think just before we come to the recommendations, it would be good to remind the Congress that they did set a catastrophic cap for the regional plans and that the catastrophic cap, in some respects, is a protection against some of the problems with cost-sharing.

MR. HACKBARTH: And so we could have, in the text for that matter, it goes across all three categories of plans, traditional fee-for-service, the regional PPOs and the local MA plans. And one of our consistent themes has been a level playing field. Ideally, we would get to that, which would include a catastrophic cap in all three, from my prospective.

DR. SCANLON: Except that, I think, the Congress, in some respects, was trying to make the MA plans more attractive. The fact that one of the principal concerns about traditional Medicare is that it doesn't have a cap. And knowing that the cost of that is quite significant. That's probably why they haven't addressed it directly. But this also does make the MA plans, where you also get management, more attractive.

DR. MILSTEIN: Again, relevant to the out-of-pocket cap, we have language that reads now within the plan's network. I would proposed an amendment, and formulary.

DR. REISCHAUER: Play by the rules.

DR. MILSTEIN: Exactly, play by the rules.

MR. HACKBARTH: Did people get that? The issue is whether to count out-of-pocket expenditures for nonformulary drugs towards any catastrophic limit or count expenditures outside of network for any catastrophic limit.

MS. BURKE: We've get two modifiers now. As I understand it we now have two modifiers, one of which assumes that these are illustrative rather than determinative. So that's the first question. Have we agreed that these are illustrative? So it's a for example scenario.

In that context, I am trying to understand how specific or detailed we should be on the illustrations. As I understand it, this suggestion is that we modify the out-of-pocket cap or modify both with the question of what is counted.

MR. HACKBARTH: I think it's a reference to the out-of-pocket cap bullet only.

DR. REISCHAUER: It's the reference to the fact that network doesn't cover all of the types of services and Arnie just wants to make sure that that is sort of explicit as opposed to implicit.

MS. BURKE: Okay.

MR. HACKBARTH: So basically, Arnie is saying that in requiring a catastrophic cap we shouldn't tie the plan's hands in terms of active management of the costs by saying once you hit the cap no holds are barred, you get to go wherever you want and use whatever drugs you want. And part of this option is people enroll in these plans, they buy into their management, and we shouldn't tie their hands and ability to manage.

MS. BURKE: And how is it structured in the regional? How is the catastrophic cap structured under the regional plans?

DR. BERTKO: My rough recollection is there is a number somewhere around $5,000 of out-of-pocket and then it's covered by -- there may be some cost-sharing.

MS. BURKE: But what counts towards out-of-pocket?

DR. BERTKO: In the regional? I don't know offhand. I don't know that it's specified.

DR. REISCHAUER: It's not specified in the law. I think these are going to be with the regs are going to lay this all out.

MS. BURKE: What I'm trying to understand is is there going to be an inconsistency? My only question is a consistency issue.

DR. SCHMIDT: I don't think that the regs specify a cap. The law does say that there needs to be a separate in-network and out-of-network cap.

MS. BURKE: So we presumably want consistency; right? Or do we?

MR. HACKBARTH: That's the question.

DR. REISCHAUER: I think we're getting too detailed for what this is, really. Remember, this is a solution to a problem that we are concluding doesn't really exist.

MS. BURKE: Which is fine. My only point is if we're going to put in details, then we ought to be sure that we agree that

the details are, in fact, consistent with what we expect the details to be in the regional plans or we're going to end up setting two definitions of what the cap is.

I agree that maybe the answer is not to put it in any detail. But if we're going to put in any details, then it would seem to me there's some logic to consistency so we don't end up having two definitions of what counts towards the cap, that we're suddenly suggesting can be used in creating a safe harbor.

So I'm with Bob. I'm fine to have no detail. But if we have it, then it seems to me we ought to have some knowledge of whether we're consistently defining what counts towards caps as we create them.

MS. RAPHAEL: I would prefer not to get into what should count towards the caps. I think what we're saying is the guidelines for safe harbor might include an out-of-pocket cap on cost-sharing or some limitation on cost-sharing having to do with discretionary services period. I wouldn't even mention chemotherapy, for example. I would leave it broader than that.

DR. REISCHAUER: And of course, to jump on Sheila's bandwagon here, if we were going to be consistent in these two, we would talk about cost-sharing within the network, which we haven't done.

MR. HACKBARTH: I agree with you, Arnie, on the merits of the issue. But I think we are getting too far afield for this particular purpose in prescribing detail. And so, what I'd ask that we do is just make it a reference to a cap on cost-sharing.

DR. REISCHAUER: We can elaborate in the text, too. That's the right place to have that kind of discussion.

MR. HACKBARTH: Let's do that.

MR. SMITH: I don't want to draw our solution to Bob's correctly described small problem. but I find myself uncomfortable with John's opening it up recommendation. Maybe we should say guidelines should include: rather than -- that gives the opening that John wants but it takes away the strength of this recommendation, which says there should be a catastrophic cap and there should be --

MR. HACKBARTH: I think that's a good point and consistent with his intent. It isn't limited to this list. It could be others as well. Jay?

DR. CROSSON: I'm not sure this a countercurrent suggestion, but I think what we're trying to do here is to provide continued flexibility to plans because that has a value. But I think also try to focus on a particular issue which has to do with beneficiary protection for, again, a relatively small number of vulnerable people.

I almost wonder whether this is too general an approach, although I like the first bullet point, I think that's correct. But I would almost argue that it might be better to say something like in particular, there should be protections for -- I don't get the wording here -- for beneficiaries at risk of disproportionately high cost-sharing on services that are less discretionary in nature, perhaps such as chemotherapy, and that

can be resolved either through an appropriate out-of-pocket cap on total cost-sharing or limitations on cost-sharing for those services.

So just flipping it around and narrowing it closer to the problem that is meant to be addressed. I could try to write it out.

MR. HACKBARTH: Say that one more time for me. I'm sorry, I'm getting slow.

DR. CROSSON: I think the issue that we were grappling with --

MR. HACKBARTH: Just the language part, just repeat.

DR. CROSSON: Do you want me to say exactly the same thing I said before?

It might be easier for me to write the text and write it out.

MS. THOMAS: We have it. Can you read it back?

[The reporter read the record as requested.]

DR. CROSSON: It seems to me it provides more emphasis on the problem, yet it keeps flexibility.

MR. HACKBARTH: I want to caution us about trying to word smith. Let's avoid trying to do that. I understand your point but let's keep the substance here.

I think we can take some things like chemotherapy out of the boldfaced recommendation and put them in the text and make it both sharper for you, Jay, and also a little cleaner in terms of being a recommendation in our usual format. So give us the freedom to try to polish it up.

But substantively, I think we've got agreement on this.

MR. DURENBERGER: A question relative to Medicare Advantage plans generally, and maybe a future work product. I have been thinking about what Nick said this morning and I have some apprehensions about the role that Medicare Advantage plans will play when they are fairly unrestricted in the way they are creative, as we say in here, about benefit design. I'm not sure that whatever I might have to say or he said this morning is responsive to the actual question for the study.

So I would hope that at some point in time we spend a little bit more time analyzing the whole issue of getting back to standard benefits or whatever it may be so that we have some more analysis of the plan structure as a way in which to facilitate the provider/patient relationship, not to get in the way with it, which I think is part of the argument that he was making.

When you talk about creativity of benefits, that only works to the advantage of the health plan. If you talk about creativity of services within a benefit structure, that works to the advantage of the care providers and the patients.

And I think about this particularly with regard to people who are chronically ill, who are the ones who will be probably working with their providers to determine which plan would be the best for them and things like that.

So I don't want to belabor it in the context of this, but I think that that whole context of the relationship between the

plan, the providers and the consumers, in terms of plan benefit design, deserves some discussion or some analysis at some point in time beyond this.

I hope we can do that sometime.

MR. HACKBARTH: Any other comments?

DR. MILLER: So what the game plan is is we will redraft these along the lines that you said, and hopefully, say first thing in the morning, hit it for 10 minutes or so, have you look at it, see the changes, take the vote, and be done with it.

MR. HACKBARTH: Okay. Thank you for the fast turnaround.

We will have a brief public comment period with the usual ground rules.